BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
FIROOZ SADEGHI, M.D.	Case No: 18-2000-106171
	OAH No: L2002090611
Physician's and Surgeon's Certificate No: C-40713	
Respondent.	

DECISION

The attached Amended Proposed Decision is hereby adopted as the Decision and Order of the Division of Medical Quality of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on November 1, 2004.

DATED October 1, 2004

DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA

Ronald L. Moy, M.D.
Panel B Chair
Division of Medical Quality

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: FIROOZ SADEGHI, M.D. 329 W. Lomita Ave., #206 Glendale, CA 91204-1662 Physician's and Surgeon's Certificate No. C 40713 Respondent.	Case No. 18-2000-106171 OAH No. L2002090611 **ORDER CORRRECTING PROPOSED DECISION PURSUANT TO GOVERNMENT CODE SECTION 11518.5**

On September 17, 2004, Administrative Law Judge Humberto Flores of the Office of Administrative Hearings issued a Proposed Decision in the above captioned matter. The Proposed Decision contained errors in findings 10, 11 and 12, which have been corrected in the Amended Proposed Decision that is attached to this Order of Correction. The changes in these findings necessitate corrections in the Legal Conclusion No. 7, and in No. 3 of the Order.

Findings 10, 11 and 12 are corrected as follows:

10. The evidence did not establish that respondent, through his authorized biller, submitted bills for services purportedly rendered to patient Carlos R. on approximately 18 occasions between February 20, 1998 and February 8, 1999.

11. The evidence did not establish that respondent, through his authorized biller, submitted bills for services purportedly rendered to patient Connie R. on approximately 10 occasions between January 30, 1998 and February 8, 1999.

12. The evidence did not establish that respondent, using the fictitious name of Sunland Medical Associates, Inc., and through his authorized biller, submitted bills for services purportedly rendered to patient Waldo F. on approximately 28 occasions between November 18, 1998 and October 27, 1999.

Legal Conclusion No. 7 is corrected as follows:

7. Cause exists to order respondent to pay a $500.00 penalty for each violation of Business and Professions Code section 2262. Findings 7 and 8 set forth that false bills were

submitted to insurers for two different persons based on numerous purported visits by these persons to the medical clinic that employed respondent. The investigative report (exhibit 7) indicates that there were attachments to the report which included billing records, spread sheets, and medical records of the purported patients. These attachments were not included in exhibit 7. It would therefore be speculative to rule that a medical record was created for each purported visit and billed separately for each patient. Based on the evidence, the undersigned will impose a civil penalty of $500.00 for each patient for a total civil penalty of $1,000.00.

No. 3 of the Order is corrected as follows:

3. Respondent Firooz Sadeghi shall pay $1,000.00 as a civil penalty pursuant to Business and Professions Code 2262.

This Order Correcting the Proposed Decision and the Amended Proposed Decision are hereby made part of the record.

The agency shall serve respondent with the original Proposed Decision, a copy of this Order, and the Amended Proposed Decision.

IT IS SO ORDERED

Dated: September 20, 2004

Humberto Flores

HUMBERTO FLORES
Administrative Law Judge
Office of Administrative Hearings

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: FIROOZ SADEGHI, M.D. 329 W. Lomita Ave., #206 Glendale, CA 91204-1662 Physician's and Surgeon's Certificate No. C 40713 Respondent.	Case No. 18-2000-106171 OAH No. L2002090611

AMENDED PROPOSED DECISION

This matter was heard by Humberto Flores, Administrative Law Judge with the Office of Administrative Hearings, on August 10, 2004, in Los Angeles, California.

Deputy Attorney General T. Douglas MacCartee represented Complainant David T. Thorton, Interim Executive Director of the Medical Board of California, Department of Consumer Affairs.

Respondent Firooz Sadeghi, M.D., did not appear though he was properly served with the Accusation, Amended Accusation and Notice of Hearing pursuant to Government Code sections 11505 and 11509. All jurisdictional requirements were met and the matter proceeded by default. The matter was deemed submitted on August 15, 2004, when the undersigned reviewed the declarations submitted pursuant to Government Code section 11514.

On September 17, 2004, the Administrative Law Judge issued a Proposed Decision which contained errors in findings 10, 11 and 12. On September 20, 2004, the Administrative Law Judge issued an "Order Correcting Proposed Decision..." and an Amended Proposed Decision. The original Proposed Decision issued on September 17, 2004, is hereby vacated and replaced by this Amended Proposed Decision.

FACTUAL FINDINGS

1. David T. Thornton ("Complainant") made the Accusation and Amended Accusation in his official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On October 25, 1982, the Medical Board of California issued Physician's and Surgeon's Certificate No. C 40713 to Firooz Sadeghi, M.D. ("Respondent").

3. On January 15, 1998, respondent, due to non-payment of child support, was issued a temporary 150 day license with an expiration date of June 30, 1998. Effective July 1, 1998, respondent's license was placed on suspension due to non-compliance.

4. On January 20, 1999, respondent's license was returned to active status and was in full force until its expiration on January 31, 2004.

Fraud and Dishonesty

5. On or about September 1998, during the time that respondent's license was under suspension, respondent began employment at a medical clinic located 271 S. Atlantic Boulevard in Los Angeles, California. The clinic was owned by a person not licensed as a physician and surgeon. Respondent was paid $4,000.00 per month by the non-licensee to be at the clinic and to say, if asked. "I am [the] doctor." Respondent was told that he did not have to see patients and in fact did not see patients.

6. Respondent authorized the non-licensee owner of the medical clinic to bill insurers on his behalf.

7. Respondent, through his authorized biller, submitted bills totaling more than $5,000.00 for services purportedly rendered to patient Juan R. on approximately 26 or more occasions between January 29, 1997 and July 6, 1999. In fact, the services were not rendered as billed.

8. Respondent, through his authorized biller, submitted bills totaling more than $7,500.00 for services purportedly rendered to patient Alma R. on approximately 34 or more occasions between December 29, 1997 and July 23, 1999. In fact, the services were not rendered as billed.

9. On or about February 6, 2001, in response to a request for records from the Board, respondent, through this authorized representative, submitted false and fraudulent medical records relating to his purported care and treatment of Juan R. and Alma R.

10. The evidence did not establish that respondent, through his authorized biller, submitted bills for services purportedly rendered to patient Carlos R. on approximately 18 occasions between February 20, 1998 and February 8, 1999.

11. The evidence did not establish that respondent, through his authorized biller, submitted bills for services purportedly rendered to patient Connie R. on approximately 10 occasions between January 30, 1998 and February 8, 1999.

12. The evidence did not establish that respondent, using the fictitious name of Sunland Medical Associates, Inc., and through his authorized biller, submitted bills for services purportedly rendered to patient Waldo F. on approximately 28 occasions between November 18, 1998 and October 27, 1999.

General Unprofessional Conduct/Dishonesty

13. On March 9, 2003, at approximately 1230 hours, respondent removed his penis from his trousers and masturbated in full public view on the upper level parking facility of SEARS, Glendale, California. Respondent made no attempt to conceal his act from members of the public and security personnel.

14. On March 9, 2003, at about 1300 hours, respondent was arrested for indecent public exposure and later pled guilty to one count charging a violation of Penal Code section.415, subdivision (2), disturbing the peace, a misdemeanor.

15. On May 14, 2003, respondent was interviewed by a representative of the Board in connection with the medical billing matters set forth in findings 5 through 12. During that interview respondent was asked if he had ever been arrested. Respondent stated that he had never been arrested despite his arrest that occurred on March 9, 2003.

Gross Negligence, Repeated Negligent Acts and Incompetence

16. Patient Gayane Y., a 71 year-old female (72" height/259 lbs.) first presented to respondent on May 1, 2001, with multiple complaints. After performing a physical examination, respondent diagnosed "Chest pain, hypertension, hyperlipidemia (elevated level of lipids in the plasma), shortness of breath and osteoarthritis." An EKG revealed a possible myocardial infarction.

17. The patient returned on May 22, 2001, for a "check-up", complaining of calf pain, varicose veins pain and arthralgia (joint pain). The patient returned 14 months later on August 1, 2002. Respondent noted a history including hypertension, asthma and arthritis. A vasospect (venous flow studies), which previously had been normal, now suggested deep vein thrombosis in the left leg. A renal ultrasound disclosed several cystic masses on the left kidney. An in-house EKG result was consistent with possible ischemic coronary disease. The patient's blood tests showed elevated sodium at 153 and cholesterol of 264. LDL cholesterol was measured.

18. Patient Gayane Y. returned on August 28, 2002 for a follow-up visit. Only vital signs were taken. The records do not reflect that respondent performed a physical, or that he discussed prior examinations or diagnostic studies. Further, respondent did not prescribe medication, and no follow-up visit interval was recorded.

19. In connection with his treatment of patient Gayane Y., respondent failed to: (1) conduct a detailed "chest pain" or coronary history; (2) conduct a full physical exam; (3) inform the patient of abnormal examination results or pursue additional diagnostic testing based on abnormal test results; and (4) failed to perform cancer screening exams or refer the patient to a specialist. In addition, respondent failed to follow-up on several masses on the patient's left kidney and failed to conduct established tests to screen for cancer. Respondent's care and treatment of patient Gayane Y. was an extreme departure from the standard of care.

20. Patient Rosa B., a 62 year-old female, first presented to respondent on March 8, 2001. The patient had multiple complaints, including abdominal pain, dyspepsia, and constipation. Further, the patient had a history of asthma, tachycardia, hypertension, and chest pain. Respondent's brief physical resulted in an assessment that included dyspepsia, abdominal pain, cholecystitis (inflammation of the gall bladder), cough, asthma and chest pain. Among abnormal tests results were an ultrasound that revealed a sizable gall stone, a renal ultrasound that revealed a cyst on the left renal cortex, and an ECG showing mild mitral regurgitation. Respondent prescribed a Proventil inhaler and baby aspirin.

21. On March 28, 2001, Rosa B. returned for a check-up and complained of tachycardia, myalgia, shoulder pain and generalized osteopenia (reduced bone mass). Vital signs were taken, but the records do not indicate that respondent performed a physical. Respondent prescribed Baclofen 10 mg.

22. Five months later, on September 10, 2001, Rosa B. returned with multiple complaints, including shortness of breath, palpitations, hypertension, and abdominal, leg, and back pain. Respondent repeated a blood chemistry which established H. Pylori stomach infection. Ultrasounds established lower extremities arterial stenosis of 20-40%.

23. The patient returned on September 28, 2001, for follow-up of her lab results. The patients file reflects that the only test or study recorded was the vasospect (venous flow studies) results suggesting "deep venous" thrombosis (DVT) of the right leg. The vasospect, which previously was normal, now suggested "consider deep vein thrombosis" in the left leg.

24. Respondent failed to take or record full histories and physicals on the patient. Respondent failed to follow-up by testing, treatment or referral on positive findings of gallstones, H. Pylori or lower limb DVT. Respondent's failure to record full histories and physicals, and to refer the patient for any of the conditions set forth above, was an extreme departure from the standard of care.

25. Patient Roza B., a 72 year-old female, first saw the respondent on September 18, 2000, and gave a written history of heart disease, diabetes, arthritis and hospitalization within the last two years. Based on a limited physical, respondent's assessment included diabetic neuropathy, hypertension, osteoarthritis and stress incontinence. Blood and urine tests revealed elevated blood glucose and related abnormalities as well as hepatitis S and B antibodies. A nerve conducting study was "suggestive of diabetic neuropathy."

26. The patient returned on November 13, 2000, with complaints of generalized osteopenia and weakness with myalgia. Vital signs were taken, but no physical was recorded. Bone density studies and venous flow studies were ordered and the results were consistent with osteopenia. Respondent wrote a note indicating that he should "consider deep venous thrombosis." Respondent did not take action on either of these test results. In addition, respondent did not order that the patient's glucose be measured.

27. On May 11, 2001, respondent ordered an EKG and spirometry. The records do not reflect that respondent performed a physical examination. The results of the EKG showed "possible anterior myocardial infarction (MI)." The spirometry showed mild restriction and an echocardiogram showed evidence of mild pulmonic and aortic valve regurgitations. Respondent initialed the echocardiogram as a "Cardiology Consult."

28. On the patient's last visit on June 20, 2001, she complained of fatigue, tachycardia, and a history of heat disease, hypertension, arthritis and diabetes. The physical examination was limited to vital signs and a description of ear wax, back tenderness, and tachycardia. There was no mention about the abnormal results of the EKG or the "cardiology consult."

29. Respondent failed to: (1) take a detailed history; (2) conduct a detailed physical directed at the chief complaints and to document any of the same; (3) initiate control measures for the patient's blood sugars; (4) test for cancers; and (5) take any action on the results of the EKG finding of possible myocardial infarction and of the venous flow studies which suggested DVT. Respondent's care and treatment of patient Roza B. was an extreme departure from the standard of care.

30. Patient Sventlana M., a 42 year-old female, first saw respondent on September 28, 2001. A history of heart disease, osteoarthritis and obesity was recorded. Assessment included obesity, edema, osteoarthritis, low back pain, varicose veins and numbness of upper body. Multiple tests and studies were conducted without medical indication.

//

//

31. The patient returned on October 23, 2001 for follow-up. The results of these tests allegedly include "bilateral carpal tunnel" per respondent's interpretations, "deep venous thrombosis" of the left leg and "echogenicity of the liver and partial obstruction of the pancreas and spleen." Blood tests revealed infiltration of the liver and were positive for H. Pylori, ANA (antinuclear antibodies) and RF (rheumatoid factor). Respondent did not note that a physical was performed. Finally, respondent prescribed Augmentin, Prayachol and Pevacid.

32. Respondent failed to take and record complete histories and physicals, excessively tested the patient, and failed to properly treat for an H. Pylori infection. Respondent's care and treatment of patient Svetlana M. was an extreme departure from the standard of care.

33. Patient Rima G., a 64 year old female, saw respondent on six occasions. On January 30, 2001, Patient Rima G. presented with a history of asthma, angina pectoris, hypertension and hepatitis. Her complaints were calf pain, myalgia, cough, chest pain and joint pain. Respondent assessed chest, knee, abdominal and calf pain as well as cough, osteoarthritis and intermittent claudication (limping). Multiple tests and studies were done. An EKG was normal, and a spirometry showed mild restrictions. Further, blood chemistries revealed elevate cholesterol (246), triglycerides (245) and LDL (137), and a Vitamin B12 level over 3000 (3 times the upper limit of normal). Respondent prescribed asthma inhalers, Cardiazen and Nitroglycerin tablets. There was no history or documentation as to whether this patient had ever take Nitroglycerine.

34. The patient returned for a check-up on February 9, 2001. She complained of leg pain, varicose veins, osteoporosis generalized, weakness and hyperlipidemia. Respondent did not perform a physical. Respondent assessed the patient with "Urinary tract infection," based on prior urinalysis. Bone density and other studies were conducted and the results included osteopenia and DVT. She was given a prescription for Procardia, 10 mg, an anti-hypertensive agent. Respondent did not record a physical or a discussion with the patient regarding previous test results.

35. The patient returned on May 2, 2001. She complained of pain and numbness in her arms and shoulder, and of carpal tunnel syndrome. Respondent did not perform a physical but prescribed a diuretic and a muscle relaxer.

36. On October 10, 2001, the patient complained of shortness of breath, palpitations, abdominal pain and claudication. Her blood pressure was 140/80 and she had gained 8 pounds. Respondent recorded an S-4 gallop, a systolic ejection murmur, wheezing, epigastric tenderness and absent lower extremity pulses. An EKG report stating "Anteroseptal infarction." with a recommendation to "consult a specialist," was initialed by respondent. No such action or consultation was taken.

37. On November 2, 2001, the patient returned with palpitations and severe knee pain. Respondent did not perform a physical. There was no notation of any discussions on the previous abnormal EKG or the patient's heart condition.

38. On September 6, 2002, the patient returned and complained of multiple somatic symptoms, including radiating chest pain. On this date a detailed history was taken. A detailed differential diagnosis was also recorded. Extensive testing revealed DVT. An echocardiogram showed an ejection fraction of 65%

39. On September 28, 2002, when the patient returned for the last time, abnormal results of prior tests were entered in the chart and she was started on Lipitor for hyperlipidemia.

40. Respondent failed to take or document a comprehensive history and physical for the first 4 visits, a period of some 21 months, and failed to properly direct his physical examination and treatment to the serious conditions documented by respondent. Respondent also failed to perform routine preventive cancer screening, and failed to act on a grossly abnormal EKG indicating an acute myocardial infarction. Respondent's care and treatment of patient Rima G. was an extreme departure from the standard of care.

41. Patient Amazon A., a 77 year-old male, first saw respondent on April 21, 2001, for the purpose of getting a complete physical. His history included hypertension, heart disease and thyroid disease. Vital signs were taken and assessment was documented as "tachycardia, lower abdomen tenderness, low back tenderness, and non-palpable dorsal pulses." Extensive testing was done. Blood/UA testing was positive for H. Pylori, fasting glucose of 112 and a PSA level of 16. Respondent prescribed Norvasc, Motrin, Econtrin and Pepcid.

42. The patient returned on April 30, 2001, for a follow-up at which time the patient complained of spinal pain and leg pain. A previous elevated PSA was noted as follows: "He need urologist consult." The bone densitometry evidenced osteopenia, venous flow studies were interpreted as "Consider venous insufficiency?" Respondent did not perform a physical and only prescribed a calcium supplement.

43. On September 28, 2001, the patient returned with complaints of chest pain, leg pain, back pain, palpitations and shortness of breath. A hand written note by respondent dated September 29, 2001, was directed to: "To any hospital of patient's choice, [a] urologist or urology department: PSA is 16, needs biopsy and evaluation. Please inform me of the results." The PSA level of 16 was known to respondent 5 months earlier.

44. Respondent failed to complete and record full histories and physicals, failed to confirm the 1st PSA reading at 16, failed to immediately refer the patient to a specialist, and failed to follow-up on the referral. Respondent also failed to perform a rectal-prostate exam. Respondent's care and treatment of patient Amazon A., was an extreme departure from the standard of care.

45. Complainant did not submit certifications of costs of investigation, enforcement and prosecution of this matter pursuant to Business and Professions Code section 125.3.

LEGAL CONCLUSIONS

1. Cause exist to suspend or revoke respondent's Physician's and Surgeon's Certificate under Business and Professions Code sections 2234, subdivision (e), 2261, 2262 and 810, in that respondent billed insurers for medical services that he did not render or allowed his authorized agents to bill for the non-rendered services, as set forth in findings 7 and 8.

2. Cause exist to suspend or revoke respondent's Physician's and Surgeon's Certificate under Business and Professions Code section 2264, in that respondent aided and abetted the unlicensed practice of medicine, as set forth in findings 5 through 8.

3. Cause exist to suspend or revoke respondent's Physician's and Surgeon's Certificate under Business and Professions Code section 2052, in that respondent engaged in the practice of medicine during the period that his certificate had been placed on suspension, as set forth in finding 5.

4. Cause exist to suspend or revoke respondent's Physician's and Surgeon's Certificate under Business and Professions Code section 2234, in that respondent engaged in general unprofessional conduct, as set forth in findings 13 and 14.

5. Cause exist to suspend or revoke respondent's Physician's and Surgeon's Certificate under Business and Professions Code section 2234, subdivision (e), in that respondent engaged in dishonest conduct, as set forth in findings 5 through 9, and finding15.

6. Cause exist to suspend or revoke respondent's Physician's and Surgeon's Certificate under Business and Professions Code section 2234, subdivisions (b), (c) and (d), in that respondent was grossly negligent and incompetent, and committed repeated negligent acts, as set forth in findings 16 through 44.

7. Cause exists to order respondent to pay a $500.00 penalty for each violation of Business and Professions Code section 2262. Findings 7 and 8 set forth that false bills were submitted to insurers for two different persons based on numerous purported visits by these persons to the medical clinic that employed respondent. The investigative report (exhibit 7) indicates that there were attachments to the report which included billing records, spread sheets, and medical records of the purported patients. These attachments were not included in exhibit 7. It would therefore be speculative to rule that a medical record was created for each purported visit and billed separately for each patient. Based on the evidence, the undersigned will impose a civil penalty of $500.00 for each patient for a total civil penalty of $1,000.00.

8. Cause exists to revoke respondent's approval to supervise a physician's assistant pursuant to Business and Professions Code section 3527, subdivision (c) based on a determination that respondent engaged in unprofessional conduct as set forth in findings 5 through 44.

9. Cause does not exist to award reasonable costs of investigation and enforcement in this matter under Business and professions Code section 125.3 since complainant did not present certification of costs.

ORDER

1. Physician's and Surgeon's Certificate No. C 40713, previously issued to respondent Firooz Sadeghi, M.D., is hereby revoked.

2. Respondent's approval to supervise physician's assistants is revoked pursuant to Business and Professions Code section 3527, subdivision (c).

3. Respondent Firooz Sadeghi shall pay $1,000.00 as a civil penalty pursuant to Business and Professions Code 2262.

DATED: September 20, 2004

Humberto Flores

HUMBERTO FLORES
Administrative Law Judge
Office of Administrative Hearings

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: FIROOZ SADEGHI, M.D. 329 W. Lomita Ave., #206 Glendale, CA 91204-1662 Physician's and Surgeon's Certificate No. C 40713 Respondent.	Case No. 18-2000-106171 OAH No. L2002090611

PROPOSED DECISION

This matter was heard by Humberto Flores, Administrative Law Judge with the Office of Administrative Hearings, on August 10, 2004, in Los Angeles, California.

Deputy Attorney General T. Douglas MacCartee represented Complainant David T. Thorton, Interim Executive Director of the Medical Board of California, Department of Consumer Affairs.

Respondent Firooz Sadeghi, M.D., did not appear though he was properly served with the Accusation, Amended Accusation and Notice of Hearing pursuant to Government Code sections 11505 and 11509. All jurisdictional requirement have been met and the matter proceeded by default. The matter was deemed submitted on August 15, 2004, when the undersigned reviewed the declarations submitted pursuant to Government Code section 11514.

FACTUAL FINDINGS

1. David T. Thornton ("Complainant") made the Accusation and Amended Accusation in his official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On October 25, 1982, the Medical Board of California issued Physician's and Surgeon's Certificate No. C 40713 to Firooz Sadeghi, M.D. ("Respondent").

3. On January 15, 1998, respondent, due to non-payment of child support, was issued a temporary 150 day license with an expiration date of June 30, 1998. Effective July 1, 1998, respondent's license was placed on suspension due to non-compliance.

4. On January 20, 1999, respondent's license was returned to active status and was in full force until its expiration on January 31, 2004.

Fraud and Dishonesty

5. On or about September 1998, during the time that respondent's license was under suspension, respondent began employment at a medical clinic located 271 S. Atlantic Boulevard in Los Angeles, California. The clinic was owned by a person not licensed as a physician and surgeon. Respondent was paid $4,000.00 per month by the non-licensee to be at the clinic and to say, if asked. "I am [the] doctor." Respondent was told that he did not have to see patients and in fact did not see patients.

6. Respondent authorized the non-licensee owner of the medical clinic to bill insurers on his behalf.

7. Respondent, through his authorized biller, submitted bills totaling more than $5,000.00 for services purportedly rendered to patient Juan R. on approximately 28 or more occasions between January 29, 1997 and July 6, 1999. In fact, the services were not rendered as billed.

8. Respondent, through his authorized biller, submitted bills totaling more than $7,500.00 for services purportedly rendered to patient Alma R. on approximately 33 or more occasions between December 29, 1997 and July 23, 1999. In fact, the services were not rendered as billed.

9. On or about February 6, 2001, in response to a request for records from the Board, respondent, through this authorized representative, submitted false and fraudulent medical records relating to his purported care and treatment of Juan R. and Alma R.

10. Respondent, through his authorized biller, submitted bills totaling approximately $3,454.00 for services purportedly rendered to patient Carlos R. on approximately 18 occasions between February 20, 1998 and February 8, 1999. In fact, the services were not rendered as billed.

11. Respondent, through his authorized biller, submitted bills totaling approximately $2,826.00 for services purportedly rendered to patient Connie R. on approximately 10 occasions between January 30, 1998 and February 8, 1999. In fact, the services were not rendered as billed.

12. Respondent, using the fictitious name of Sunland Medical Associates, Inc., and through his authorized biller, submitted bills totaling approximately $10, 000.00 for services purportedly rendered to patient Waldo F. on approximately 28 occasions between November 18, 1998 and October 27, 1999. In fact, the services were not rendered as billed.

General Unprofessional Conduct/Dishonesty

13. On March 9, 2003, at approximately 1230 hours, respondent removed his penis from his trousers and masturbated in full public view on the upper level parking facility of SEARS, Glendale, California. Respondent made no attempt to conceal his act from members of the public and security personnel.

14. On March 9, 2003, at about 1300 hours, respondent was arrested for indecent public exposure and later pled guilty to one count charging a violation of Penal Code section.415, subdivision (2), disturbing the peace, a misdemeanor.

15. On May 14, 2003, respondent was interviewed by a representative of the Board in connection with the medical billing matters set forth in findings 5 through 12. During that interview respondent was asked if he had ever been arrested. Respondent stated that he had never been arrested despite his arrest that occurred on March 9, 2003.

Gross Negligence, Repeated Negligent Acts and Incompetence

16. Patient Gayane Y., a 71 year-old female (72" height/259 lbs.) first presented to respondent on May 1, 2001, with multiple complaints. After performing a physical examination, respondent diagnosed "Chest pain, hypertension, hyperlipidemia (elevated level of lipids in the plasma), shortness of breath and osteoarthritis." An EKG revealed a possible myocardial infarction.

17. The patient returned on May 22, 2001, for a "check-up", complaining of calf pain, varicose veins pain and arthralgia (joint pain). The patient returned 14 months later on August 1, 2002. Respondent noted a history including hypertension, asthma and arthritis. A vasospect (venous flow studies), which previously had been normal, now suggested deep vein thrombosis in the left leg. A renal ultrasound disclosed several cystic masses on the left kidney. An in-house EKG result was consistent with possible ischemic coronary disease. The patient's blood tests showed elevated sodium at 153 and cholesterol of 264. LDL cholesterol was measured.

18. Patient Gayane Y. returned on August 28, 2002 for a follow-up visit. Only vital signs were taken. The records do not reflect that respondent performed a physical, or that he discussed prior examinations or diagnostic studies. Further, respondent did not prescribe medication, and no follow-up visit interval was recorded.

19. In connection with his treatment of patient Gayane Y., respondent failed to: (1) conduct a detailed "chest pain" or coronary history; (2) conduct a full physical exam; (3) inform the patient of abnormal examination results or pursue additional diagnostic testing based on abnormal test results; and (4) failed to perform cancer screening exams or refer the patient to a specialist. In addition, respondent failed to follow-up on several masses disclosed on the patient's left kidney and failed to conduct established tests to screen for cancer. Respondent's care and treatment of patient Gayane Y. was an extreme departure from the standard of care.

20. Patient Rosa B., a 62 year-old female, first presented to respondent on March 8, 2001. The patient had multiple complaints, including abdominal pain, dyspepsia, and constipation. Further, the patient had a history of asthma, tachycardia, hypertension, and chest pain. Respondent's brief physical resulted in an assessment that included dyspepsia, abdominal pain, cholecystitis (inflammation of the gall bladder), cough, asthma and chest pain. Among abnormal tests results were an ultrasound that revealed a sizable gall stone, a renal ultrasound that revealed a cyst on the left renal cortex, and an ECG showing mild mitral regurgitation. Respondent prescribed a Proventil inhaler and baby aspirin.

21. On March 28, 2001, Rosa B. returned for a check-up and complained of tachycardia, myalgia, shoulder pain and generalized osteopenia (reduced bone mass). Vital signs were taken, but the records do not indicate that respondent performed a physical. Respondent prescribed Baclofen 10 mg.

22. Five months later, on September 10, 2001, Rosa B. returned with multiple complaints, including shortness of breath, palpitations, hypertension, and abdominal, leg, and back pain. Respondent repeated a blood chemistry which established H. Pylori stomach infection. Ultrasounds established lower extremities arterial stenosis of 20-40%.

23. The patient returned on September 28, 2001, for follow-up of her lab results. The patients file reflects that the only test or study recorded was the vasospect (venous flow studies) results suggesting "deep venous" thrombosis (DVT) of the right leg. The vasospect, which previously was normal, now suggested "consider deep vein thrombosis" in the left leg.

24. Respondent failed to take or record full histories and physicals on the patient. Respondent failed to follow-up by testing, treatment or referral on positive findings of gallstones, H. Pylori or lower limb DVT. Respondent's failure to record full histories and physicals, and to refer the patient for any of the conditions set forth above, was an extreme departure from the standard of care.

25. Patient Roza B., a 72 year-old female, first saw the respondent on September 18, 2000, and gave a written history of heart disease, diabetes, arthritis and hospitalization within the last two years. Based on a limited physical, respondent's assessment included diabetic neuropathy, hypertension, osteoarthritis and stress incontinence. Blood and urine tests revealed elevated blood glucose and related abnormalities as well as hepatitis S and B antibodies. A nerve conducting study was "suggestive of diabetic neuropathy."

26. The patient returned on November 13, 2000, with complaints of generalized osteopenia and weakness with myalgia. Vital signs were taken, but no physical was recorded. Bone density studies and venous flow studies were ordered and the results were consistent with osteopenia. Respondent wrote a note indicating that he should "consider deep venous thrombosis." Respondent did not take action on either of these test results. In addition, respondent did not order that the patient's glucose be measured.

27. On May 11, 2001, respondent ordered an EKG and spirometry. The records do not reflect that respondent performed a physical examination. The results of the EKG showed "possible anterior myocardial infarction (MI)." The spirometry showed mild restriction and an echocardiogram showed evidence of mild pulmonic and aortic valve regurgitations. Respondent initialed the echocardiogram as a "Cardiology Consult."

28. On the patient's last visit on June 20, 2001, she complained of fatigue, tachycardia, and a history of heat disease, hypertension, arthritis and diabetes. The physical examination was limited to vital signs and a description of ear wax, back tenderness, and tachycardia. There was no mention about the abnormal results of the EKG or the "cardiology consult."

29. Respondent failed to: (1) take a detailed history; (2) conduct a detailed physical directed at the chief complaints and to document any of the same; (3) initiate control measures for the patient's blood sugars; (4) test for cancers; and (5) take any action on the results of the EKG finding of possible myocardial infarction and of the venous flow studies which suggested DVT. Respondent's care and treatment of patient Roza B. was an extreme departure from the standard of care.

30. Patient Sventlana M., a 42 year-old female, first saw respondent on September 28, 2001. A history of heart disease, osteoarthritis and obesity was recorded. Assessment included obesity, edema, osteoarthritis, low back pain, varicose veins and numbness of upper body. Multiple tests and studies were conducted without medical indication.

//

//

31. The patient returned on October 23, 2001 for follow-up. The results of these tests allegedly include "bilateral carpal tunnel" per respondent's interpretations, "deep venous thrombosis" of the left leg and "echogenicity of the liver and partial obstruction of the pancreas and spleen." Blood tests revealed infiltration of the liver and were positive for H. Pylori, ANA (antinuclear antibodies) and RF (rheumatoid factor). Respondent did not note that a physical was performed. Finally, respondent prescribed Augmentin, Prayachol and Pevacid.

32. Respondent failed to take and record complete histories and physicals, excessively tested the patient, and failed to properly treat for an H. Pylori infection. Respondent's care and treatment of patient Svetlana M. was an extreme departure from the standard of care.

33. Patient Rima G., a 64 year old female, saw respondent on six occasions. On January 30, 2001, Patient Rima G. presented with a history of asthma, angina pectoris, hypertension and hepatitis. Her complaints were calf pain, myalgia, cough, chest pain and joint pain. Respondent assessed chest, knee, abdominal and calf pain as well as cough, osteoarthritis and intermittent claudication (limping). Multiple tests and studies were done. An EKG was normal, and a spirometry showed mild restrictions. Further, blood chemistries revealed elevate cholesterol (246), triglycerides (245) and LDL (137), and a Vitamin B12 level over 3000 (3 times the upper limit of normal). Respondent prescribed asthma inhalers, Cardiazen and Nitroglycerin tablets. There was no history or documentation as to whether this patient had ever take Nitroglycerine.

34. The patient returned for a check-up on February 9, 2001. She complained of leg pain, varicose veins, osteoporosis generalized, weakness and hyperlipidemia. Respondent did not perform a physical. Respondent assessed the patient with "Urinary tract infection," based on prior urinalysis. Bone density and other studies were conducted and the results included osteopenia and DVT. She was given a prescription for Procardia, 10 mg, an anti-hypertensive agent. Respondent did not record a physical or a discussion with the patient regarding previous test results.

35. The patient returned on May 2, 2001. She complained of pain and numbness in her arms and shoulder, and of carpal tunnel syndrome. Respondent did not perform a physical but prescribed a diuretic and a muscle relaxer.

36. On October 10, 2001, the patient complained of shortness of breath, palpitations, abdominal pain and claudication. Her blood pressure was 140/80 and she had gained 8 pounds. Respondent recorded an S-4 gallop, a systolic ejection murmur, wheezing, epigastric tenderness and absent lower extremity pulses. An EKG report stating "Anteroseptal infarction." with a recommendation to "consult a specialist," was initialed by respondent. No such action or consultation was taken.

37. On November 2, 2001, the patient returned with palpitations and severe knee pain. Respondent did not perform a physical. There was no notation of any discussions on the previous abnormal EKG or the patient's heart condition.

38. On September 6, 2002, the patient returned and complained of multiple somatic symptoms, including radiating chest pain. On this date a detailed history was taken. A detailed differential diagnosis was also recorded. Extensive testing revealed DVT. An echocardiogram showed an ejection fraction of 65%

39. On September 28, 2002, when the patient returned for the last time, abnormal results of prior tests were entered in the chart and she was started on Lipitor for hyperlipidemia.

40. Respondent failed to take or document a comprehensive history and physical for the first 4 visits, a period of some 21 months, and failed to properly direct his physical examination and treatment to the serious conditions documented by respondent. Respondent also failed to perform routine preventive cancer screening, and failed to act on a grossly abnormal EKG indicating an acute myocardial infarction. Respondent's care and treatment of patient Rima G. was an extreme departure from the standard of care.

41. Patient Amazon A., a 77 year-old male, first saw respondent on April 21, 2001, for the purpose of getting a complete physical. His history included hypertension, heart disease and thyroid disease. Vital signs were taken and assessment was documented as "tachycardia, lower abdomen tenderness, low back tenderness, and non-palpable dorsal pulses." Extensive testing was done. Blood/UA testing was positive for H. Pylori, fasting glucose of 112 and a PSA level of 16. Respondent prescribed Norvasc, Motrin, Econtrin and Pepcid.

42. The patient returned on April 30, 2001, for a follow-up at which time the patient complained of spinal pain and leg pain. A previous elevated PSA was noted as follows: "He need urologist consult." The bone densitometry evidenced osteopenia, venous flow studies were interpreted as "Consider venous insufficiency?" Respondent did not perform a physical and only prescribed a calcium supplement.

43. On September 28, 2001, the patient returned with complaints of chest pain, leg pain, back pain, palpitations and shortness of breath. A hand written note by respondent dated September 29, 2001, was directed to: "To any hospital of patient's choice, [a] urologist or urology department: PSA is 16, needs biopsy and evaluation. Please inform me of the results." The PSA level of 16 was known to respondent 5 months earlier.

44. Respondent failed to complete and record full histories and physicals, failed to confirm the 1st PSA reading at 16, failed to immediately refer the patient to a specialist, and failed to follow-up on the referral. Respondent also failed to perform a rectal-prostate exam. Respondent's care and treatment of patient Amazon A., was an extreme departure from the standard of care.

45. Complainant did not submit certifications of costs of investigation, enforcement and prosecution of this matter pursuant to Business and Professions Code section 125.3.

LEGAL CONCLUSIONS

1. Cause exist to suspend or revoke respondent's Physician's and Surgeon's Certificate under Business and Professions Code sections 2234, subdivision (e), 2261, 2262 and 810, in that respondent billed insurers for medical services that he did not render or allowed his authorized agents to bill for the non-rendered services, as set forth in findings through 5 through 12.

2. Cause exist to suspend or revoke respondent's Physician's and Surgeon's Certificate under Business and Professions Code section 2264, in that respondent aided and abetted the unlicensed practice of medicine, as set forth in findings 5 through 12.

3. Cause exist to suspend or revoke respondent's Physician's and Surgeon's Certificate under Business and Professions Code section 2052, in that respondent engaged in the practice of medicine during the period that his certificate had been placed on suspension, as set forth in finding 5.

4. Cause exist to suspend or revoke respondent's Physician's and Surgeon's Certificate under Business and Professions Code section 2234, in that respondent engaged in general unprofessional conduct, as set forth in findings 13 and 14.

5. Cause exist to suspend or revoke respondent's Physician's and Surgeon's Certificate under Business and Professions Code section 2234, subdivision (e), in that respondent engaged in dishonest conduct, as set forth in findings 5 through 12 and finding15.

6. Cause exist to suspend or revoke respondent's Physician's and Surgeon's Certificate under Business and Professions Code section 2234, subdivisions (b), (c) and (d), in that respondent was grossly negligent and incompetent, and committed repeated negligent acts, as set forth in findings 16 through 44.

7. Cause exists to order respondent to pay a $500.00 penalty for each violation of Business and Professions Code section 2262. The Amended Accusation and the underlying investigative report set forth that false bills were submitted to insurers for four different persons based on numerous purported visits by these persons to the medical clinic that employed respondent. The investigative report (exhibit 7) indicates that there were attachments to the report which included billing records, spread sheets, and medical records of the purported patients. These attachments were not included in exhibit 7. It would be speculative to rule that a medical record was created for each purported visit. Therefore, the undersigned will impose a civil penalty of $500.00 for each patient for a total civil penalty of $2,000.00.

8. Cause exists to revoke respondent's approval to supervise a physician's assistant pursuant to Business and Professions Code section 3527, subdivision (c) based on a determination that respondent engaged in unprofessional conduct as set forth in findings 5 through 44.

9. Cause does not exist to award reasonable costs of investigation and enforcement in this matter under Business and professions Code section 125.3 since complainant did not present certification of costs.

ORDER

1. Physician's and Surgeon's Certificate No. C 40713, previously issued to respondent Firooz Sadeghi, M.D., is hereby revoked.

2. Respondent's approval to supervise physician's assistants is revoked pursuant to Business and Professions Code section 3527, subdivision (c).

3. Respondent Firooz Sadeghi shall pay $2,000.00 as a civil penalty pursuant to Business and Professions Code 2262.

DATED: September 17, 2004

Humberto Flores

HUMBERTO FLORES
Administrative Law Judge
Office of Administrative Hearings

BILL LOCKYER, Attorney General
of the State of California
DOUGLAS MACCARTEE, State Bar No. 77252
Deputy Attorney General
California Department of Justice
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2072
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: FIROOZ SADEGHI, M.D. 126 S. Jackson Street, #205 Glendale, CA 91205 Physician's and Surgeon's Certificate No. C 40713 Respondent.	Case No. 18-2000-106171 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. David T. Thornton (Complainant) brings this Accusation solely in his official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about October 25, 1982, the Medical Board of California issued Physician's and Surgeon's Certificate No. C 40713 to Firooz Sadeghi, M.D. (Respondent). On January 15, 1998, respondent, due to non-payment of child support, was issued a temporary 150 day license with an expiration date of June 30, 1998. Effective July 1, 1998, respondent's license was denied and placed on suspension due to non-compliance. On January 20, 1999, respondent's license was returned to active status. Except as noted herein, respondent's Physician's and

Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and has expired as of January 31, 2004.

JURISDICTION

3. This Accusation is brought before the Division of Medical Quality, Medical Board of California (Division), under the authority of the following sections of the Business and Professions Code (Code).

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Division deems proper.

5. Section 2234 of the Code states:

"The Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

6. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

7. Section 2262 of the Code states:

"Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

"In addition to any other disciplinary action, the Division of Medical Quality or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section."

8. Section 2264 of the Code states:

"The employing, directly or indirectly, the aiding, or the abetting of any unlicenced person or any suspended, revoked, or unlicenced practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct."

9. Section 2052 of the Code states:

"Any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter, or without being authorized to perform such act pursuant to a certificate obtained in accordance with some other provision of law, is guilty of a misdemeanor."

10. Section 810 of the Code states:

"(a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his or her professional activities:

"(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.

"(2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or to allow it to be presented or used in support of any false or fraudulent claim.

"(b) It shall constitute cause for revocation or suspension of a license or certificate for a health care professional to engage in any conduct prohibited under Section 1871.4 of the Insurance Code or Section 550 of the Penal Code.

"(c) As used in this section, health care professional means any person licensed or certified pursuant to this division, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act."

11. Section 125.3 of the Code provides, in pertinent part, that the Division may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

12. Section 14124.12 of the Welfare and Institutions Code states, in pertinent part:

"(a) Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

FIRST CAUSE FOR DISCIPLINE

(Fraud and Dishonesty)

13. Respondent is subject to disciplinary action under sections 2234(e), 2261, 2262 and 810 in that he billed insurers for medical services not rendered or allowed his authorized agents to bill on his behalf for such services. The circumstances are set forth below.

14. On or about September 1998, respondent began employment at a medical clinic located at 271 S. Atlantic Boulevard in Los Angeles, California. The clinic was owned by a person not licensed as a physician and surgeon. Respondent was paid $4,000.00 per month by the non-licensee to be at the clinic and to say, if asked, "I am [the] doctor." Respondent was told that he did not have to see patients and he did not see patients.

15. Respondent authorized the non-licensee to bill insurers on his behalf.

Patients Juan and Alma R.

16. Respondent, through his authorized biller, submitted bills totaling more than $5,000.00 for services purportedly rendered to patient Juan R. on approximately 28 or more occasions between January 29, 1997 and July 6, 1999. In fact, the services were not rendered as billed.

17. Respondent, through his authorized biller, submitted bills totaling more than $7,500.00 for services purportedly rendered to patient Alma R. on approximately 33 or more occasions between December 29, 1997 and July 23, 1999. In fact, the services were not rendered as billed.

18. On or about February 6, 2001, in response to a request for records from the Board, respondent, through his authorized representative, submitted false and fraudulent medical records relating to his purported care and treatment of Juan R. and Alma R.

Patients Carlos and Connie R.

19. Respondent, through his authorized biller, submitted bills totaling approximately $3,454.00 for services purportedly render to patient Carlos R. on approximately 18 occasions between February 20, 1998 and February 8, 1999. In fact, the services were not rendered as billed.

20. Respondent, through his authorized biller, submitted bills totaling approximately $2,826.00 for services purportedly render to patient Connie R. on approximately 10 occasions between January 30, 1998 and February 8, 1999. In fact, the services were not rendered as billed.

Patients Waldo F.

21. Respondent, using the fictitious name of Sunland Medical Associates, Inc., through his authorized biller, submitted bills totaling approximately $10,000.00 for services purportedly rendered to patient Waldo F. on approximately 28 occasions between November 18, 1998 and October 27, 1999. In fact, the services were not rendered as billed.

SECOND CAUSE FOR DISCIPLINE

(Aiding and Abetting Unlicensed Practice)

22. Respondent is subject to disciplinary action under section 2264 in that aided and abetted the unlicensed practice of medicine by practicing medicine as an employee of a non-licensee as set forth in paragraphs 13 through 20, which are incorporated herein by reference as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Unlicensed Practice)

23. Respondent is subject to disciplinary action under section 2052 in that engaged in the practice of medicine while not licensed as set in paragraphs 13 through 20, which are incorporated herein by reference as if fully set forth.

FOURTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

24. Respondent is subject to disciplinary action under section 2234 in that he engaged in general unprofessional conduct as set forth in paragraphs 12 through 22 above which are incorporated herein by reference as if fully set forth.

///

///

///

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct/Dishonesty)

25. Respondent is subject to disciplinary action under section 2234 and 2234(e)in that he engaged in general unprofessional conduct as set forth in the following particulars:

A. On or about March 9, 2003, at approximately 1230 hours, respondent did remove his penis from his trousers and masturbate in full public view on the upper level parking facility of SEARS, Glendale, California, without effort to conceal himself, knowing that he would be seen by members of the public. Said act was seen by members of the public and security personnel.

B. On or about March 9, 2003, at about 1300 hours, respondent was arrested for indecent public exposure and later plead guilty to P.C. 415(2) Disturbing the Peace, a misdemeanor.

C. On or about May 14, 2003, respondent was interviewed by representative of the Board in connection with the medical billing matters set forth herein. During that interview respondent was asked if he had ever been arrested. Respondent denied that he had never been arrested. In fact, he was arrested five days prior to the interview.

SIXTH CAUSE FOR DISCIPLINE

(Gross Negligence, Repeated Negligent Acts, Incompetence)

26. Respondent is subject to disciplinary action under sections 2234(b), (c) and (d) in that he was grossly negligent, committed repeated negligent acts and was incompetent, in the following particulars:

27. Patient Gayane Y.

A. Patient Gayane Y., a 71 year old female [72" height/ 259 lbs.] first presented to respondent on May 1, 2001, with multiple complaints which, after physical examination, respondent diagnosed as "Chest pain, hypertension, hyperlipidemia, shortness of breath and osteoarthritis." An EKG revealed a possible myocardial infarction.

B. The patient returned on May 22, 2001, for a "check-up" complaining of calf pain, varicose veins pain and arthralgia. The patient returned 14 months later on August 1,

2002. Respondent noted a history including hypertension, asthma and arthritis. A vasospect (venous flow studies), which previously was normal, now suggested "consider deep vein thrombosis," in the left leg. Renal ultrasound disclosed several cystic masses on the left kidney. An in-house EKG results was consistent with possible ischemic coronary disease. The patient's blood tests showed elevated sodium at 153 and cholesterol of 264. LDL cholesterol was measured.

C. Patient Gayane Y. returned on August 28, 2002 for follow-up. Only vital signs were taken. No physical was given, no discussion of the prior examinations or diagnostic studies occurred, no prescriptions were given and no follow-up visit interval was recorded.

D. At no visit did respondent conduct a detailed "chest pain" or coronary history, conduct a full physical, inform the patient of abnormal examination results or pursue additional diagnostic testing based on abnormal test results and/or refer the patient to a specialist. In addition, respondent failed to follow-up on several masses disclosed on the patient's left kidney and failed to conduct established tests to screen for cancer.

28. Patient Rosa B.

A. Patient Rosa B., a 62 year old female, first presented to respondent on March 8, 2001, with multiple complaints, including abdominal pain, dyspepsia, constipation and a history of asthma and chest pain. Respondent's brief physical resulted in an assessment that included dyspepsia, abdominal pain, cholecystitis, cough , asthma and chest pain. Among abnormal tests results were an ultrasound that revealed a sizable gall stone, a renal ultrasound that revealed a cyst on the left renal cortex and an ECG showing mild mitral regurgitation. Respondent prescribed a Proventil inhaler and baby aspirin.

B. On March 28, 2001, Rosa B. returned for a check-up with complaints of tachycardia, myalgia, shoulder pain and generalized osteopenia. Other than vital signs, no physical was performed. Respondent prescribed Baclofen 10 mg.

C. Five months later, on September 10, 2001, Rosa B. returned with multiple complaints, including shortness of breath, palpitations, hypertension, and abdominal, leg and

///

back pain. Repeated blood chemistry established H. Pylori infection. Ultrasounds established lower extremities arterial stenosis of 20-40%.

D. The patient returned on September 28, 2001, for follow-up of her lab results. The patients file reflects that the only test or study recorded was the vasospect results suggesting "deep venous" thrombosis [DVT] of the right leg. A vasospect (venous flow studies), which previously was normal now suggested "consider deep vein thrombosis" in the left leg.

E. Respondent failed to take or record full histories and physicals on the patient. Respondent failed to follow-up by testing, treatment or referral on positive findings of gallstones, H. Pylori or lower limb DVT. Respondent failed to refer the patient on any condition, including the DVT finding.

30. Patient Roza B.

A. Patient Roza B., a 72 year old female, first saw the respondent on September 18, 2000, giving a written history of heart disease, diabetes, and arthritis and hospitalization within the last two years. Based on his limited physical, respondent's assessment included diabetic neuropathy, hypertension, osteoarthritis and stress incontinence. Blood and urine tests revealed elevated blood glucose and related abnormalities and hepatitis S and B antibodies. A nerve conduction study was "suggestive of diabetic neuropathy."

B. The patient returned on November 13, 2000, with complaints of generalized osteopenia and weakness with myalgia. Vital signs were taken, but no physical was performed. Bone density studies and venous flow studies were ordered which returned consistent with osteopennia and respondent wrote that he should "consider deep venous thrombosis." No action was ever taken on either of these test results and the patient's glucose was not measured..

C. On May 11, 2001, respondent ordered and EKG and spirometry. No physical examination was done. The results of the EKG showed "possible anterior myocardial infarction(MI)." The spirometry showed mild restriction and an echocardiogram showed evidence of mild pulmonic and aortic valve regurgitations. Respondent initialed the echocardiogram as a "Cardiology Consult."

///

D. On the patient's last visit on June 20, 2001, there were similar multiple complaints, but no physical beyond vital signs and ear wax description. There was no mention about the abnormal results of the EKG or the "cardiology consult."

E. Respondent failed to take a detailed history, conduct a detailed physical directed at the chief complaints, to document any of the same, initiate control measures for the patient's blood sugars, test for cancers, or take any action on the results of the EKG finding of possible myocardial infarction.

31. Patient Sventlana M.

A. Patient Sventlana M., a 42 year old female, first saw respondent on September 28, 2001. A history of heart disease, osteoarthritis and obesity was recorded. Assessment included obesity, edema, osteoarthritis, low back pain, varicose veins and numbness of upper body. Multiple tests and studies were conducted without indication therefore.

B. The patient returned on October 23, 2001 for follow-up. The results of these tests allegedly include "bilateral carpal tunnel" per respondent's interpretation, "deep venous thrombosis" of the left leg and "echogenicity of the liver and partial obstruction of the pancreas and spleen." Blood tests revealed infiltration of the liver and were positive for H. Pylori, ANA and RF. No physical was performed. The patient received prescriptions for Augmentin, Pravachol and Prevacid.

C. Respondent failed to take and record complete histories and physicals, excessively tested the patient and failed to properly treat for found infection of the blood [H. Pylori].

32. Patient Rima G.

A. Patient Rima G., a 64 year old female, saw respondent on six occasions beginning on January 30, 2001, when she presented with a history of asthma, angina pectoris, hypertension and hepatitis. Her current complaints were calf pain, myalgia, cough, chest pain and joint pain. Respondent assessed chest, knee, abdominal and calf pain as well as cough, osteoarthritis and intermittent claudication. Multiple tests and studies were done. An EKG was normal, spirometry show mild restrictions, blood chemistries revealed elevated cholesterol (246;

triglycerides (245) and LDL (137) with Vitamin B12 level over 3000 or 3 times the upper limit of normal. Respondent prescribed asthma inhalers, Cardiazen and nitroglycerin tablets. There was no history or documentation as to whether this patient had ever take nitroglycerine.

B. The patient returned for a check-up on February 9, 2001. She complained of leg pain, varicose veins, osteoporosis generalized, weakness and hyperlipidemia. No physical was done. Respondent assessed her with "Urinary tract infection," based on prior urinalysis. Bone density and other studies were conducted and the results included osteopenia and DVT. She was given a prescription for Procardia, 10 mg, an anti-hypertensive agent. No physical or discussions of the previous test results were recorded.

C. The patient returned on May 2, 2001. She complained of pain and numbness in the arms, shoulder and carpal tunnel syndrome. No physical was done. She was prescribed diuretics and a muscle relaxer.

D. On October 10, 2001, the patient complained of shortness of breath, palpitations, abdominal pain and claudication. Her blood pressure was 140/80 and she had gained 8 pounds. Respondent recorded an S-4 gallop, a systolic ejection murmur, wheezing, epigastric tenderness and absent lower extremity pulses. An EKG report stating "Anteroseptal infarction," with a recommendation to "consult a specialist," which was initialed by respondent. No such action or consultation was taken.

E. On November 2, 2001, the patient returned with palpitations and severe knee pain. No physical was performed. There was no notation of any discussions on the previous abnormal EKG or the patient's heart condition.

F. On September 6, 2002, the patient returned after 10 months complaining of multiple somatic symptoms, including radiating chest pain. On this date a detailed history was taken. A detailed differential diagnosis was also recorded. Extensive testing revealed DVT. An echocardiogram showed an ejection fraction of 65%.

G. On September 28, 2002, the patient returned for the last time, abnormal results of prior tests were entered in the chart and she was started on Lipitor for hyperlipidemia.

///

H. Respondent failed to take or document a comprehensive history and physical for the first 4 visits, a period of some 21 months, failed to properly direct his physical examination and treatment to the serious conditions documented by himself, failed to perform routine preventive cancer screening, and failed to act on a grossly abnormal EKG indicating an acute myocardial infarction.

33. Patient Amazon A.

A. Patient Amazon A., a 77 year old male, first saw respondent on April 21, 2001, for the purpose of getting an complete physical. His history included hypertension, heart disease and thyroid disease. Vital sign were taken and assessment was documented as "tachycardia, lower abdomen tenderness, low back tenderness, and non-palpable dorsal pulses." Extensive testing was done. Blood/UA testing was positive for H. Pylori, fasting glucose of 112 and a P.S.A. of 16. Respondent prescribed Norvasc, Motrin, Ecotrin and Pepcid.

B. The patient returned on April 30, 2001, for a follow-up at which he complained of spinal pain and leg pain. A previous elevated PSA was noted as follows: "He needs urologist consult." The bone densitometry evidenced osteopenia, venous flow studies were interpreted as "Consider venous insufficiency?" No physical examination occurred and the patient received a prescribed calcium supplement.

C. On September 28, 2001, the patient returned with complaints of chest pain, palpitations, shortness of breath and back and leg pain. A hand written note by respondent dated September 29, 2001 was addressed to: "To any hospital of patient's choice, a urologist o urology department: PSA is 16, needs biopsy and evaluation. Please inform me of the results." The PSA level of 16 was known to respondent 5 months earlier.

D. Respondent failed to complete and record full histories and physicals, respondent failed to confirm the 1st PSA reading at 16, thereafter failed to immediately refer the patient to a specialist, and failed to follow-up to assure the patient was seen. Respondent also failed to do a rectal-prostate exam.

///

///

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division of Medical Quality issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. C 40713, issued to Firooz Sadeghi, M.D.;

2. Ordering Firooz Sadeghi, M.D. to pay the Division of Medical Quality a civil penalty of $500.00 for each violation of section 2262;

3. Revoking, suspending or denying approval of Firooz Sadeghi, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

4. Ordering Firooz Sadeghi, M.D. to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

5. Taking such other and further action as deemed necessary and proper.

DATED: 5/07/2004.

DAVID T. THORNTON
Interim Executive Officer
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

03573160-SD02AD0161
03573160-SD04AD0066
First Amended Accusation.tdm: 05/03/2004